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COMMITTEE ON THE ELIMINATION OF
DISCRIMINATION AGAINST WOMEN
Seventeenth session
7-25 July 1997
Item 6 of the provisional agenda*

IMPLEMENTATION OF ARTICLE 21 OF THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Reports provided by specialized agencies of the United Nations on the implementation of the Convention in areas falling within the scope of their activities

Note by the Secretary-General

Addendum

WORLD HEALTH ORGANIZATION

1. On behalf of the Committee, the Secretariat invited the World Health Organization (WHO), on 15 April 1997, to submit to the Committee by 15 May 1997 a report on information provided by States to WHO on the implementation of article 12 and related articles of the Convention on the Elimination of All Forms of Discrimination against Women, which would supplement the information contained in the reports of those States parties to the Convention to be considered at the seventeenth session.

2. Other information sought by the Committee refers to the activities, programmes and policy decisions undertaken by WHO to promote the implementation of article 12 and related articles of the Convention.

3. The report annexed hereto has been submitted in compliance with the Committee's request.

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ANNEX

WORLD HEALTH ORGANIZATION: REPORT TO THE SEVENTEENTH SESSION OF THE COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN
(Relevant to Article 12 of the Convention)

1. INTRODUCTION

The global community has called for a new global commitment to making women full partners with men in the social, economic and political lives of communities. At the core of equal participation is the recognition that access to primary health care - including reproductive health care - is indispensable to women. Healthier women have a greater capacity for productive work both inside and outside the home. In turn, women's empowerment and education lead to better health for women and their families.

Even though the health community has come a long way since the beginning of the United Nations Decade for Women (1976 - 1985), we find ourselves faced with the same obstacles to women's health and well-being identified then. Poverty, inequitable relationships between men and women, women's unequal access to health care and education, and social and cultural factors that discriminate against girls and women still stand in the way.

The World Health Organization, as the technical agency responsible for global public health, seeks to improve the relationships between women and health care providers, needs and services. Women and men in many countries have little access to health care, particularly if they are poor. Women often face additional barriers to the use of health services due to social or cultural practices. Barriers such as time and travel costs may pose greater obstacles for women, as do health system deficiencies. There is a need to improve quality of care through improving the technical competence of health care providers, as well as their interpersonal skills, and ensuring the availability of essential supplies, equipment and medication. The norms and guidelines for quality must be responsive to women's needs and concerns.

Women will necessarily remain at the focus of health activities, but efforts should be increased to facilitate their involvement in programme development so that they become participants in, rather than objects of, health interventions.

Because women suffer disproportionate ill-health, grounded in gender differences, WHO continues to focus its efforts on seeking out women's voices and ensuring they are integrated into its strategies and activities.

2. WORKING TO DIMINISH GENDER DISPARITIES IN HEALTH

Gender disparities in health are a consequence of both biologic and social differences between the sexes. Among biologic differences, women's capacity for reproduction, and all of its consequent health risks, has a major impact on the differential health experiences of men and women. But other biologic factors such as the different manifestations of sexually transmitted diseases between men and women, e.g., the greater tendency for asymptomatic syndromes in women, also contribute to greater reproductive morbidities among women than men.

Most troubling, however, are the differential health risks between men and women that are a consequence, not of biological differences between the sexes, but of social and behavioural disparities. In Latin America and the Caribbean, 31% of girl children are underweight, compared with 17% of boys. In India's rural Punjab, poverty takes a bigger toll on the nutrition of girls than that of boys: 21% of the girls in low income families suffer severe malnutrition, compared with 3% of boys in the same families (UNDP, 1995). Gender inequalities in most societies are characterized by an unequal balance of power which results in women and girls having less access to, and control over, economic, political and health resources. This leads to greater poverty among women, reduced access to education, and increased levels of both disability and long-term morbidity among women. WHO has a fundamental obligation to promote women's health and rights, and gender equality as a vital means of ensuring health for all.

3. NUTRITION

Dealing with the nutritional needs of girls and women throughout their lives implies developing strategies to end discrimination in terms of food allocation and nutritional status. An enormous burden of ill-health is associated with malnutrition which causes wasting, blindness from Vitamin A deficiency, mental retardation from iodine deficiency, and widespread iron deficiency anaemia. Malnutrition affects women and girls more than boys, both because of discrimination in feeding and health care and because of the extra demands for energy and iron imposed by menstruation, childbearing and lactation. Malnutrition also contributes to increased morbidity and death from a variety of infectious and chronic diseases. Anaemia, which affects some 450 million women aged between 15 and 49 years, is the most widespread and neglected nutritional deficiency disease in the world today. It is largely a problem for women, particularly during pregnancy and lactation. The World Health Organization's Nutrition Programme is working to implement a range of interventions targeting anaemia, including modification of dietary patterns, alternative treatment schedules and delivery systems for iron supplementation to overcome problems such as lack of compliance and logistic difficulties, and food fortification.

Improving women's nutritional status, in particular, removing the burden of chronic fatigue with accompanied anaemia, will be a vital step in breaking the cycle of neglect and ill-health. The commitments made in the Plan of Action on Nutrition of the International Conference on Nutrition and reaffirmed in Beijing including a reduction worldwide of severe and moderate malnutrition among children under the age of five by one half of 1990 levels by the year 2000, giving special attention to the gender gap in nutrition, and a reduction in iron deficiency anaemia in girls and women by one third of the 1990 levels by the year 2000, should be used for monitoring progress towards improving women's nutritional status.

4. GLOBAL COMMISSION ON WOMEN'S HEALTH

The Global Commission on Women's Health was established in 1993 as a high-level advocacy body in response to resolution WHA45.25 on women, health and development emanating from the technical discussions at the Forty-fifth World Health Assembly in 1992. The objective of the Commission is to accelerate action at the national and international level

to improve women's health as their fundamental human right in keeping with the Constitution of the World Health Organization. In carrying out its objective, the Global Commission on Women's Health had a fourfold mission:

- producing an agenda for action on women's health focusing on a few select areas capable of yielding the most significant progress;
- raising awareness of women's health concerns among policy makers through the use of sex disaggregated data on women's health and their socioeconomic situation;
- advocating the women's health issues as a priority within development plans and ensuring that these issues are articulated at all major national, regional and international fora on women and development;
- providing a forum for consultation and dialogue with women's health advocacy groups and others who mobilize women from the grassroots to the highest political levels.

The Global Commission on Women's Health considered the political, economic, social and technological changes taking place in the world today and examined the impact of these changes on the health of the women throughout their life-span.

In this analysis, the four concepts deemed to be crucial to effecting change in women's health were:

1. The right to health as expressed in women's right to health security;
2. The need for a holistic approach to women's health from in utero through to old age;
3. The necessity of applying a gender approach to the health of both women and men throughout their lifespan;
4. The value of women's health in a market-oriented world.

The Global Commission has operated within the context of WHO's work in establishing that health is central to the achievement of economic and social development.

The main achievement of the Global Commission has been the articulation of the human rights framework for women's health. The Global Commission has elevated the consideration of women's health from the limitations of earlier concentrations on reproductive health, to a lifecycle approach. It has promoted a more in-depth analysis of a number of women's health issues by highlighting the disadvantaged health status of girls and women throughout their lifecycle, included are the health impact of violence against women and girls; women's occupational health and the health of ageing women.

The Global Commission has produced an agenda for women's health focusing on six priorities: nutrition, reproductive health, health consequences of violence, ageing, life-style

related conditions and the work environment.

Its advocacy role has been critical in ensuring a place for women's health in the action plans adopted in recent UN Conferences such as the International Conference on Population and Development, the World Summit for Social Development and the Fourth World Conference on Women

The Commission is continuing to focus on identifying inadequacies in policy and action, both within WHO's programmes and globally, as well as on developing strategies for action. The six WHO regions have initiated studies in their member countries to gather data on women's health, including their socioeconomic situation. These have been completed by the WHO Regional Office for Europe in 37 of its member states which include Armenia and Israel. The mandate of the Global Commission is very relevant to the provisions as stated in Article 12 of the Convention.

5. VIOLENCE AGAINST WOMEN

The long term aims of WHO activities in the area of violence against women are to identify effective strategies to prevent violence and to decrease morbidity and mortality among women victims of abuse. Its specific objectives include:

a) to increase the available knowledge of the magnitude of the problem and its health consequences and disseminate it among policy-makers, health providers and programme planners;

b) to identify appropriate prevention and intervention strategies that can reduce the prevalence/incidence of violence against women;

c) to improve the capacity of health workers at all levels to identify and respond appropriately to victims of mental, physical and sexual abuse;

d) to support the formulation, by national governments, of adequate anti-violence policies and protocols; and

e) to serve as an advocate within WHO and with professional health associations, for greater recognition of the implications of physical, mental and sexual violence against women for health policies, programmes and training.

The planned and ongoing activities of the Plan of Action on violence against women include:

a) a multi-country (Gambia, Namibia, Pakistan, Peru, Philippines, Russian Federation, Thailand and Uzbekistan) study on the prevalence and health consequences of violence against women;

b) support to documenting existing interventions and the development and testing of new ones for the prevention of violence against women and the management

of its consequences;

c) development of a data base on violence against women;

d) development of advocacy and information materials;

e) improve the accessibility of health services, by training health workers, for women affected by violence, in situations of conflict and displacement.

6. FEMALE GENITAL MUTILATION

Female genital mutilation (FGM) is a deeply rooted traditional practice that has a significant negative impact on the health of girls and women especially in its severe forms. It is estimated that over 130 million girls and women have undergone some form of female genital mutilation and two million girls are at risk of this practice. The women affected live in 28 African countries, a few in the Middle East and in Asia. Female genital mutilation is also an emerging issue in immigrant communities in Europe, US, Canada, Australia and in New Zealand.

Over the years, WHO's governing bodies have adopted a number of resolutions urging Member States *inter alia* to establish clear national policies to end female genital mutilation and requesting WHO to strengthen its technical and other support to the countries concerned. The Organization is seeking to develop its activities in this area in a holistic way, bringing together the work of different programmes in order to draw up recommendations that are consistent with the provision of integrated reproductive health programmes. WHO's four main strategies are:

- to play an advocacy role by emphasizing the importance of action against harmful practices at international, regional and national levels;

- to initiate and coordinate the research and development being undertaken by international agencies, nongovernmental organizations and national authorities;

- to support national networks or organizations and groups involved in developing relevant policies, strategies and programmes;

- to support the training of health professionals in the prevention of female genital mutilation and the management of its health consequences.

There are current gaps in knowledge on the prevalence and incidence of FGM in countries, on the underlying social, cultural, ethnic and economic factors that predict and influence this practice as well as on the morbidity by type of operation in the communities. Even less has been documented on the psychosexual and mental health effects on women and on girls and on the management of the health complications. In most of those countries where FGM still prevails, health care providers are not cognizant of the urgent need to educate the public as to the possible harmful effects and/or they lack the communication skills or motivation to carry out the task. Indeed, in some instances, the economic interests of health

care providers conflict with prevention efforts, as they have increasingly taken it upon themselves to perform female genital mutilation.

The Women's Health unit of WHO (WHD) began activities on FGM in 1995 with a focus on increasing the available knowledge on FGM and developing a sound technical basis for policy and action at country level. A joint WHO/UNICEF/UNFPA Statement on female genital mutilation, which expresses the common purpose of the three organizations in supporting governments and communities to promote and protect the health and development of women and children has recently been published. An updated Information Kit is also available to primary health care workers, NGOs and the media.

For the three year period (1997-1999), the main focus of activities would be on research and development which includes the development of norms and standards for the care of women and girls suffering from the health consequences of FGM as well as developing tools and a framework for health care providers to work with the subject. An essential task to be undertaken is the development of training materials on FGM.

While a new generation of "FGM-sensitive" health providers are being created, seminars and on-job-training will be provided for existing staff to improve their communication skills and educate them about the immediate and long-term consequences of FGM. This is expected to be a major regional activity.

7. GENDER EQUALITY IN ACCESS TO HEALTH CARE SERVICES (APS)

The overall aim of the Women's Health (WHD) unit is to contribute to the promotion and improvement of women's health and rights and to the development of health programmes and policies that promote gender equality in health. The programme works to promote understanding of the linkages between women's health and social development, to foster increased attention to women's reproductive and human rights, and to diminish gender disparities in health.

Gender is a significant marker of social and economic vulnerability which is manifest in inequalities of access to health care.

i) lack of resources: women tend on the whole to be poorer than men, to have less access to income earning opportunities and other resources, and to be more dependent on others for their longer term security. Thus, access to resources for health expenditure may be lower.

ii) cultural factors: access to utilization of health services may be influenced by cultural and ideological factors, such as embargoes on consulting male practitioners and the lack of freedom to act without permission from their husbands.

iii) at the household level the division of labour tends to place greater burdens on women's time, resulting in higher opportunity costs for women in seeking treatment.

It is extremely difficult to assess the current situation regarding equality of access to health care services for women. Although some studies have looked into financial barriers of access to care, very little data is available on the gender dimension.

WHO has launched an initiative focusing on equity in health and health care and collects information from countries on access to health services (Table 1). However, again there is no information on access to health care disaggregated by sex. Therefore, an aggregate improvement in the level of access to care may still disguise significant inequalities. Data on the distance women must travel to the nearest health facility or hospital is given for Namibia and the Dominican Republic (Table 1).

However, improved access is not in itself a sufficient condition for achieving equality in terms of health status. It is also necessary to consider the mix of services on offer. Information on the level of access to health facilities gives no insight into what services are provided at these facilities.

The lack of sex disaggregated information on access to care does hinder adequate evaluation of the situation for women. WHO is currently looking into identifying appropriate indicators that address the issue of access to care and allow for disaggregation by sex.

8. PROVIDING APPROPRIATE SERVICES TO WOMEN IN CONNECTION WITH PREGNANCY, CONFINEMENT AND THE POSTNATAL PERIOD

Women have additional, specific health needs which derive from biology and reproductive health risks. Therefore, there is a need to provide specific, women focused health care interventions as a basic right in order to address this imbalance of need.

Safe Pregnancy - Safe childbirth

Women who chose to have a child should have access to quality care for herself and for her infant. The denial of such care through lack of material resources or lack of social "status" is an affront to human rights and dignity. Despite this, revised estimates of maternal mortality - calculated using a new approach developed by WHO and UNICEF - indicate that globally 585 000 women die each year from the complications of pregnancy, 99% of them in developing countries. Because maternal mortality levels reflect the status of women, their access to health care, and the adequacy of the health system in responding to their needs then we are faced with the simple truth that in many parts of the world, women are being failed by the societies they live in.

In an effort to improve the experience of childbearing for millions of women, WHO has identified clusters of well-delineated, cost-effective interventions that are likely to be important everywhere. One example is the Mother-Baby Package which incorporates aspects of both family planning and Sexually Transmitted Disease management around the core of maternity care and defines the minimum programmes and services needed to eliminate the burden of maternal and perinatal ill-health.

After a decade of concerted international effort, we now know the true cost of

TABLE 1

	HFA 2000[1]	WHO estimates[2]				DHS data[3,4]	
	1988-90	1996			1993	% women living more	% women living more
	Pop with access to health care (%)*	Antenatal care (%)	Institutional delivery (%)	Skilled personnel at delivery (%)	Skilled personnel at delivery (%)	than 5km from nearest health facility	than 5km from nearest hospital
World total	-	68	46	57	60	-	-
More developed regions	-	97	98	99	99	-	-
Less developed regions	-	65	40	53	55	-	-
Antigua and Barbuda	88	-	-	-	-	-	-
Argentina	92	-	90	96	92	-	-
Armenia	-	95	95	95	100+	-	-
Australia	100	-	-	-	-	-	-
Bangladesh	74	23	5	14	7	-	-
Dominican Republic	71	97	92	90	92	14 *	36 *
Israel	100	90	99	99	99	-	-
Italy	100	-	-	-	-	-	-
Luxembourg	100	-	-	-	-	-	-
Namibia	-	88	67	68	68	38	62

*Population covered for treatment of common diseases and injuries, including availability of essential drugs on the national list within one hour's walk or travel

+Figure for former USSR

*Offering maternal and child health services

[1] World Health Organisation. *Health for All 2000 database*, Geneva 1996

[2] World Health Organisation *Coverage of Maternity Care. A Tabulation of available information*, Geneva 1996

[3] Demographic and Health Surveys (DHS). *Dominican Republic. Demographic and Health Survey 1991*

[4] Demographic and Health Surveys (DHS). *Namibia. Demographic and Health Survey 1993*

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motherhood for millions of women worldwide - and we also know what is needed if this tragic situation is to improve. As part of this shift, WHO and its partners in the Safe Motherhood Inter-Agency Group will convene a technical consultation - to be held in Sri Lanka in October 1997 - so that the lessons which have been learned from the last ten years can be consolidated and a clear consensus on which strategies are most effective in reducing maternal and newborn death and disability can be reached - but this is only part of what we must now be looking to achieve. The real goal of the consultation is to present what is known and to invite the attending decision-makers and planners from government and nongovernmental organizations, technical specialists, researchers, donors and representatives of multilateral agencies to decide which lessons and research results are most relevant to their current needs.

Safe pregnancy-safe childbirth is a core principle of WHO's work and a cornerstone of reproductive health. In addressing women's needs for safe choices in pregnancy, WHO is also working to protect the health of the newborn - the two are inseparably bound. In addition to its work in promoting the simple interventions which could achieve this, WHO also recognizes the importance of choice in this sphere of a woman's life - giving women a say in when, how and where their children are born can bring great benefits to the well-being of both well beyond the time of birth.

The WHO coverage of care estimates (Table 1), give an idea of the utilization rates of services connected with pregnancy and delivery for some of the reporting states. Although these are not measures of access to care, they give some indication of the under-utilization of these services in relation to the world, averages in developed and less developed region. In 1996, apart from Antigua and Barbuda for which no estimates are available, the majority of countries compare favourably with the averages for developing countries. However, the coverage rates for Bangladesh are significantly lower than the average for the less developed regions: antenatal care (23%), institutional delivery (5%) and skilled personnel at delivery (14%). In Namibia, rates of institutional delivery (67%) and skilled personnel at delivery (68%) are somewhat lower than in the other countries, although they are higher than less developed region averages.

When comparing the 1993 and 1996 skilled personnel at delivery estimates, no significant shifts appear to have occurred, except possibly in Bangladesh where the rate has doubled from 7% to 14%.

9. IMPROVING ACCESS TO QUALITY CARE IN FAMILY PLANNING

The ability to choose if, when and how many children to have is not only a key intervention for improving the health of women and children but is now recognized as a key human right. WHO's basis for action in this area is to enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have the means to do so, to ensure informed choices and to make available a full range of safe and effective methods of fertility regulation. Despite advances in contraceptive technologies and their application, however, there remain large numbers of people whose access to information and family planning services is severely restricted by a range of logistical, social and behavioural obstacles which WHO is working to remove.

Providing people with real choice in their reproductive lives involves a lot more than just putting contraceptive technologies on the shelves. Without sensitivity to the changing needs of users and to the constraints facing them in their everyday lives, and without attention to issues such as the delivery and quality of services and information, then the obstacles to access will never be overcome. As part of its commitment to improving access to high-quality care in family planning, WHO has developed and published a highly authoritative guide which not only provides detailed information on all the currently available contraceptive methods, but also covers issues such as client education and counselling, training and supervision of service providers, introduction of new methods, and programme evaluation. Intended for use and adaptation by family planning programme managers, administrators and policy-makers, the guide is designed to help in the developing of comprehensive family planning services. WHO has also condensed a number of the core issues.

There are a number of ways in which a gender perspective can be taken into account when setting the research agenda in the development, provision and use of fertility regulation technologies. WHO is following a strategy which includes stimulating dialogue with women's health groups on different aspects of its work, ensuring the participation of women's health group representatives on its scientific and policy-making committees and has established a Gender Advisory Panel. This Panel, will amongst other things, review all aspects of WHO's work with attention to gender issues and perspectives, and propose mechanisms by which gender concerns can be brought to bear across the range of WHO activities.

10. WOMEN AT DECISION-MAKING LEVELS

In order to achieve the Organization's objectives of increasing the number of women in all professional and higher graded posts (articles 7 and 8 of the Convention) as well as the participation of women in WHO programmes, technical meetings and meetings of WHO's governing bodies, several institutional mechanisms are in place: a) Steering Committee on the Employment and Participation of Women: this Committee is composed of members of the WHO Executive Board, the administration, representatives of the Director-General and of Fifty-Fifty[1]. The Steering Committee advises and makes recommendations to the Organization. Following a consultant report commissioned by the Steering Committee, the Director-General appointed a Special Adviser to the Director-General on the employment and participation of women (see (c); b) Joint Committee on the Employment and Participation of Women: this is a tripartite committee composed of representatives of the administration, the WHO Staff Committee and the Fifty-Fifty Group. This committee reports regularly on the situation regarding the employment of women in the organization and assists the administration in implementing recommendations made by the Steering Committee. A report on the situation of women at professional and higher levels was presented to the WHO Executive Board in January 1997; c) Special Adviser to the Director-General on the Employment and Participation of Women in WHO: Dr Tomris Türmen, Executive Director, Family and Reproductive Health, serves as Special Adviser to the Director-General on the Employment and Participation of Women in WHO. The Adviser is part of the Ad Hoc and

[1]Fifty-Fifty is an ad hoc group of WHO staff which has, as one of its main objectives, gender equality in the workplace.

Senior Staff Selection Committees in order to ensure the equitable consideration of women candidates for vacant posts in the professional and higher categories. The Adviser reports regularly to the Director-General on current trends and on further action needed to achieve increased participation of women in the work of WHO; d) Coordinator, Employment and Participation of Women: the Director-General made this appointment in May 1996. In this role, the Coordinator works in close collaboration with the Joint Committee and her terms of reference include identifying women both inside and outside the Organization with potential for appointment to decision-making and policy making positions in WHO stimulating a search for qualified women candidates, ientifying the major obstacles to the full and equal participation of women in the work of WHO and developing relevant strategies to overcome the obstacles.

Comparison of the situation in all established offices in 1994 and in 1996 reveals that there was an overall increase of one half of one percent in the proportion of women among all professional staff of the Organization. Two years after the deadline for the target of 30%, the total proportion of women in the professional grades participating in the Organization is 3% short of the target, which is equivalent to 10% of the target level.

With regard to grade distribution for each sex for all established offices, these figures also show that whereas 32% of female professional staff and 63% of male staff were graded at P5 or higher in 1994, the proportions had increased to 37% of female staff, and 64% of male staff by 1996. The gap in the proportion of each sex at the higher grades was thus reduced from 31% to 27% between 1994 and 1996.

The situation is exceptionally different at the highest ungraded levels of employment in the Organization. An additional position was created, raising the number of these posts to 11. At present, four women hold positions at this level, which has suddenly created a 36% participation of women at these highest levels, where previously there had been none at all.

To summarize, the participation of women at the lowest level of responsibility has seen a modest increase of 4% since 1994, and the participation of women at the highest levels of responsibility has undergone a substantial rise. At the middle to senior levels of responsibility of Associate/Deputy Director and Director, the situation has worsened overall.

The 50th WHA in May 1997 adopted a resolution on Employment and Participation of Women (WHA50.16) calling for the target for representation of women in the professional categories to be increased to 50% in WHO and for targets to be set at 50% by 2002 for new appointments of women to professional categories, representation of women as temporary advisers, consultants and on scientific and technical advisory groups.